Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: VISTA HOSPITAL OF DALLAS 4301 VISTA ROAD PASADENA, TX 77504	MFDR Tracking #: M4-09-A141-01
Respondent Name and Box #: STATE OFFICE OF RISK MANAGEMENT REP. BOX #: 45	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…It is unclear from the Explanation of Benefits what methodology Carrier used to calculate reimbursement, but because Provider did not request that the implantables be paid separately, Carrier should have reimbursed Provider pursuant to section 134.403(f)(1)(A). Carrier has severely under-reimbursed Provider by either applying the inappropriate reimbursement methodology or inappropriately calculating reimbursement under the applicable rule… Carrier's payment of $2,156.64 is still less than the amount that Vista Hospital of Dallas should have been reimbursed if it had requested that implantables be reimbursed separately under 134.403(f)(1)(B), specifically, $2,989.44. It is unclear what methodology Carrier used to calculate, but it is clear that the amount reimbursed is insufficient under the Fee Guideline. With regard to the charges at issue in this dispute, there is no evidence presented by the Carrier that the prices billed were no Provider's usual and customary charges… or that the final price was not fair and reasonable. Therefore, the Carrier is required to reimburse Provider $4,599.14 pursuant to the Outpatient Fee Guideline, which will result in fair and reasonable reimbursement for the services provided to the injured worker. The Carrier made a partial payment of $2,156.64. Therefore, the Carrier is required to reimburse Provider in the additional amount of $2,442.50, plus any and all applicable interest…"

Principle Documentation:

1. DWC 60 package
2. Hospital or Medical Bills
3. EOBs
4. Medical Reports
5. Total Amount Sought $2,442.50

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…The Office reviewed the facilities charges submitted and determined the services being performed was an excision of an abscess that had developed in or around the surgical site from the original surgery dated 4/24/08. In review of the procedure report there were **no** implants utilized in this procedure, therefore the reimbursement for REV codes 250,270 and 272 were denied correctly for B15-procedure/service is not paid separately, as CPT codes billed are not paid under OPPS, Incidental services that are include in the APC rate. In addition, CPT codes 94760 and 99144 are OPSI-N codes, indicating these codes are packaged in the APC rate. Review of CPT code 99205, the Office will maintain its denial of the Office visit code for B15-Procedure/service is not paid separately as there is not a technical component to this code, the Office visit is considered a professional code and the professional fees were reimbursed to the physician that performed the procedure. The Office performed a manual audit on all remaining codes and found that correct reimbursements were made at the APC rate times 200% in accordance with Rule §134.403, indicated as line item comments on the explanation of benefits showing the reimbursement calculations for each code that allowed a reimbursement by Medicare's OPPS. The facility has failed to provide sufficient evidence to justify a supplemental payment for the procedure performed and contends the bills were audited in accordance with the above stated rules…"

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
07/22/08	Hospital Outpatient Services	$591.93 (APC)+$1,704.08 (Outlier Amount) = $2,296.01 (OPPS) x 200% + $54.55 (Fee Schedule) = $4,646.57 - $2,156.64 (Total paid by Respondent) = $2,489.93. Requestor is seeking $2,442.50	$2,442.50	$2,442.50
			Total Due:	$2,442.50

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital Facility Fee Guideline – Outpatient,*** effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).

1. The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reason codes:
   Explanation of benefits with the listed date of audit 08/14/2008:
   - B15 – Procedure/Service is not paid separately.
   - RG3 – Included in another billed procedure.
   - W1 – Workers' Compensation State Fee Schedule adj.

   Explanation of benefits with the listed date of audit 06/24/2009:
   - B13 – Payment for service may have been previously paid.
   - B15 – Procedure/Service is not paid separately.
   - W4 – No additional payment allowed after review.

2. Rule 134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"

3. Pursuant to Rule §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.

5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:

   (1) No contract exists;

   (2) MAR can be established for these services; and

   (3) Separate reimbursement for implantables was *NOT* requested by the requestor.

   (4) According to 134.403, REV code 250, 270 and 272 (HCPCS Codes J3490 and A4649) and REV codes 370 and 460 (CPT codes 99144, 94762 and 94760) are services or procedures included in the APC rate, but not paid separately as they are considered packaged items; in addition, REV code 460 (CPT Code 94762) is a comprehensive procedure that includes one or more components which require a modifier. REV code 300 (CPT codes 85025, 80053, and 81002) are paid under a Fee Schedule or with a prospectively pre-determined rate. REV code 320 (CPT code 71020) is considered an ancillary service, paid as APCs rather than from a Fee Schedule. REV code 360 (CPT code 27570) is an outpatient significant procedure subject to multiple procedure discounting. The highest paying Status T APC is paid at 100%; all others are paid at 50%. REV code 710 (CPT Code 99205) has a Status V indicator and is defined as a clinic or Emergency Department visit that may include ER physician or personal physicians. This code is paid under OPPS; separate APC payment; however modifier -25 is required. The Requestor did not attach modifier -25, therefore, reimbursement for this code cannot be recommended. REV code 730 (CPT Code 93005) has a Status S indicator that is an outpatient significant procedure not subject to multiple procedure discounting.

6. Consequently, reimbursement will be calculated in accordance with Rule §134.403 (f)(1)(A) a follows:

APC	Outlier Amount	Separate Reimbursement for implantables WAS NOT requested under Rule §134.403	APC + Outlier Amount X 200%	Fee Schedule (CMS + DWC conversion factor)	Subtract Amount Paid by Respondent	Results in additional Amt Due to Requestor
$591.93	$1,704.08	$0.00	$2,296.01	$54.55	$2,156.64	$2,442.50 Amount Requestor is seeking

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is due additional payment. As a result, the amount ordered is $2,442.50.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. 413.011(a-d), 413.031 and 413.0311
28 TAC Rule §134.403
28 TAC Rule §133.305
28 TAC Rule §133.307

PART VII: DIVISION DECISION

The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,442.50 plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature	Medical Fee Dispute Resolution Officer	November 12, 2009 Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.